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Symptoms and Treatment of Tumors of the Bladder.

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SYMPTOMS AND TREATMENT OF TUMORS OF THE BLADDER.

The earliest and most constant symptom of tumor of the bladder is hemorrhage; this usually appears before irritation of the bladder.

When vesical tenesmus and frequency of micturition precede hemorrhage, malignancy should be suspected.

Hemorrhage from the bladder occurs towards the end of micturition. The first urine passed is clear and as the bladder empties itself it becomes blood stained, while the last urine passed is of a bright red color due to the presence of fresh blood. Following exploration of the bladder, the first urine passed is uniformly blood stained. Confusion may arise in cases of hematuria as to the source of the hemorrhage.

When the hemorrhage is from the kidney and of idiopathic origin, the blood is intimately mixed with the urine giving it a reddish brown color, while if traumatic in origin the blood is passed as clots which assume the shape of the ureters, being passed in whole or in parts. Clots from the bladder are irregular in size and shape. The hemorrhage is usually intermittent and irregular, and particularly so in the more solid tumors.

Pain, as a rule, is an unimportant symptom except in the advanced stages of the malignant forms of growths, and then usually accompanies the increased micturition. In some cases, however, there is pain referred to the loins and hips.

Characteristics of the Urine.—The urine in vesical

hematuria shows the presence of red and white blood corpuscles. Shreds and cells of the growth may be found in the normally voided urine. By forcibly washing out the bladder, particles of the growth are more likely to be found. The evacuator which is used in the crushing operation for stone is a more reliable means of securing a specimen of a growth. The lithotrite may be used to confirm the diagnosis. The stream of urine, as a usual thing, is not altered, yet in the pedunculated forms of tumors, especially when situated near the mouth of the bladder, it may be interrupted, thus simulating stone. The sensation communicated to the fingers upon the introduction of the sound frequently gives valuable information, also a digital examination per rectum or vaginam; by these means the growth may both be located and its approximate size made out. The most valuable instrument in the diagnosis of tumors of the bladder is unquestionably the cystoscope. I have repeatedly been able to diagnose the situation, size and character of bladder growths by means of this instrument, and afterwards confirmed it by operation. Digital exploration through a median perineal cystotomy, formerly a common practice, has been displaced by the cystoscope. In the female, digital exploration through the urethra will usually suffice to establish a diagnosis, but does not offer the same advantages as the cystoscope.

Treatment.—The treatment resolves itself simply into the choice of operation. Suprapubic cystotomy offers the greatest advantages in the majority of cases. By the suprapubic route more room is gained for manipulation, the interior of the bladder can be illuminated by the electric head light, thus permitting the growth to be dealt with to the best advantage, and the hemorrhage can be more readily controlled. In sessile growths, curettement is the method or removal. The pedunculated growths are best removed by the wire serre-nœud or the cautery scissors. In the latter variety of growths, if situated

near the mouth of the bladder, in the absence of great prostatic enlargement, median perineal cystotomy is the preferable operation.

I report the two following cases which illustrate the different operations:

Case 1.—Papilloma of the Bladder (Perineal Cystotomy).—C. L., age 45 years. For some months prior to admission to the German Hospital, he suffered from painful urination. The urine had frequently been charged with blood. There was present a constant dull pain in the hypogastrium. Cystoscopic examination demonstrated the existence of a sessile lobulated growth on the antero-lateral surface of the bladder. Median perineal cystotomy was decided upon as the most suitable operation. The bladder being filled with a boracic acid solution, the staff was introduced into the urethra and a median incision made from the central point of the perineum down to the staff, and thence along its groove into the bladder. A growth about the size of a small egg was revealed and thoroughly curetted from the mucous membrane. A soft catheter was passed into the bladder through the perineal wound and stitched in position. To the end of the catheter was attached a long rubber tube serving to carry off the urine into a vessel under the bed. Convalescence was uninterrupted. The perineal wound closed rapidly. The patient was discharged two weeks after the operation.

Examination of the growth showed it to be a simple papilloma. It weighed scant two ounces.

Case 2.—Suprapubic Cystotomy for Papilloma.—Perineal Cystotomy for Recurrence.—Death from Exhaustion.—G. W., age 45 years, was admitted to the German Hospital, April 15, 1893. Personal and family history good. Six months before, he suddenly developed an attack of hematuria, with dysuria. All symptoms then subsided. About a month before his admission to the hospital, the patient noticed a return of the original trouble; his condition became steadily worse, the hematuria and dysuria being alarmingly severe. The act of voluntary micturition became very difficult and finally impossible, and repeated catheterization had to be resorted to. The urethra finally became so sensitive that the passage of the catheter occasioned much suffering. The urine was always rich in blood and small clots. He was admitted with the diagnosis of a probable papilloma with blood clots in the bladder. Suprapubic cystotomy was performed. The surface being thoroughly prepared, the abdominal incision was made and the bladder exposed. The bladder was picked up with tissue forceps and a silk thread passed through its

wall for the purpose of making traction thus facilitating the next step in the operation—the incision into the bladder. This was now opened by a longitudinal incision. Examination revealed the condition suspected; the bladder was practically filled with blood in a more or less advanced stage of coagulation. Fully two handsful of clotted blood, part of which was quite firmly organized and closely adherent to the mucous membrane were removed. After it was thoroughly emptied of its contents, a close inspection of the lining membrane of the bladder revealed the existence of a small papilloma on the posterior wall.

The little growth was cut away and the bladder thoroughly irrigated with boracic acid solution. A rubber drainage tube was introduced into the bladder through the abdominal opening, and the latter closed. The patient reacted well, and convalescence was uninterrupted. At the time of his discharge, May 17, the suprapubic fistula had entirely closed, and the urine was passed without difficulty through the normal channel.

On June 30, the patient returned, giving a history of several attacks of hemorrhage since his discharge from the hospital. He now sought relief from an existing attack that had baffled all attempts made to check it. The usual styptic methods failing, it was decided to perform a perineal cystotomy. Thorough drainage was effected by the reëstablishment of the original suprapubic opening and the newly made perineal incision. One week afterwards, a violent hemorrhage took place, but was easily controlled. A growth gradually developed involving the whole bladder wall, and ulcerating through the abdominal wall.

At the autopsy, August 11, the growth, a carcinoma fully as large in size as a fetal head was removed.